Information for Physicians on Prescription Products to Treat Perinatal Depression - July 2004
Treatment decisions should be based on patient characteristics and clinical judgment.

Antidepressant	Advantages During Pregnancy	Disadvantages During Pregnancy	Recommended Dose* (mg/day)	Percent of Dose to Breastfeeding Baby**	Reported Side Effects to Breastfeeding Infants	Teratogenicity
Bupropion (**Wellbutrin**[R]; **Zyban**[R])	• No sexual side effects • No excess weight gain • Helps with smoking cessation	• No systematic studies in human pregnancy • Lowers seizure threshold • Can cause insomnia	• 200 – 300 mg	• Not known	• None reported to date	Unknown
Citalopram (**Celexa**[R])	• Few interactions with other medications	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 20 – 40 mg	• 0.7% - 9.0%	• Uneasy sleep	Morphologic – none Behavioral - unknown
Desipramine (**Norpramin**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	• 100 – 200 mg	• 1.0%	• None	None
Fluoxetine (**Prozac**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up • **Expert Consensus Guidelines top choice during pregnancy (if not planning to breastfeed)**	• Long half-life can lead to neonatal toxicity (tachypnea, respiratory distress, tremors, agitation, motor automatisms) • Increased bleeding tendency (rare)	• 20 – 60 mg	• 1.2% - 12.0%	• Vomiting, watery stools, excessive crying, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain	None
Mirtazapine (**Remeron**[R])	• No sexual side effects • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting	• No systematic studies in human pregnancy • Can cause excessive weight gain • Tends to be sedating	• 15 – 45 mg	• Not known	• Not known	Unknown
Nortryptiline (**Pamelor**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthosatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	• 50 – 150 mg	• Not known	• None	None
Paroxetine (**Paxil**[R])	• **Expert Consensus Guidelines second choice during pregnancy (if planning to breastfeed)**	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 20 – 60 mg	• 0.1% - 4.3%	• None	Morphologic – none Behavioral - unknown
Sertraline (**Zoloft**[R])	• **Expert Consensus Guidelines top choice during pregnancy (if planning to breastfeed)**	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 50 – 200 mg	• 0.4% - 1.0%	• None	Morphologic – none Behavioral - unknown
Venlafaxine (**Effexor**[R])	• Balanced antidepressant; may be effective when selective agents are not	• No behavioral studies in human pregnancy	• 75 – 225 mg	• 5.2% - 7.4%	• None	Morphologic – none Behavioral – unknown

* Physicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Dosages are from the *Physician's Desk Reference*, 56th ed. Table based on Wisner et al *Postpartum Depression* Article in *N Eng J Med*, Vol. 347, No. 3, July 18, 2002, pg. 196.

** This is a weight-adjusted estimate.

General notes:

- About 70% of women with recurrent major depression relapse during pregnancy if they discontinue antidepressant medication.
- Untreated major depression during pregnancy is associated with increased risk of preterm birth, lower birth weight, and neonatal irritability.
- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation signs in the fetus or neonate. These signs can include irritability, excessive crying, difficulty sleeping, difficulty feeding, increased tone, hyperreflexia, shivering, tachypnea, and convulsions. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.
- Pharmacokinetic changes during pregnancy can affect antidepressant dosing. For SSRI (citalopram, fluoxetine, paroxetine, sertraline) and tricyclic (desipramine, nortryptiline) antidepressants, most women need increased doses toward the second half of pregnancy to maintain a therapeutic effect.